that he has already removed all cause of obstruction, and it has probably frequently happened that patients have died because the possibility of such a complication was not thought of. The long interval between the relapses which some of the cases showed was possibly due to a temporary subsidence of the œdema present at the primary point of obstruction, caused by the rest and treatment of the secondary lesion. The occurrence of five cases in fifty-two operations performed by the author for intestinal obstruction shows that the condition is not so rare as might be supposed.

The diagnosis is materially assisted by considering the patient's statements as to where he first experienced pain and what the locality was in which the obstruction seemed to him to be situated. More certain is the observation in the early stages of peristaltic movements in the distended colon and the subsequent change in the location of the symptoms. The change is generally one from a condition in which therapeutic measures might be considered to one in which only immediate operative interference can be considered.

The symptom at the time of operation which will lead to the detection of such a condition, when it is suspected, is the contrast between the two portions of the colon. Above it is hypertrophied from the continued action required in overcoming the chronic condition prior to the complete obstruction, while below in the descending colon the intestinal wall is of normal thickness.

The Operation of Gastro-enterostomy Conjoined with Entero-anastomosis.—In discussing the present status of this operation, WEIR (*Medical Record*, April 16, 1898) summarizes his views on the subject in the following conclusions:

1. That gastro-enterostomy, as usually performed, is yet an unsatisfactory operation.
2. That its principal relievable danger is from bile or stomach retention due to operative defects, either primary or secondary—*e. g.*, spurs, kinks, twisted or distorted openings, and possibly stomach atony.
3. That a posterior stomach opening favors gravity action by the evacuation of the organ, particularly if it is atonied, and diminishes the risk of pressure or of pulling on the attached intestine.
4. That the operation is best conducted by means of the Murphy-button.
5. That a gastro-enterostomy, associated with an entero-anastomosis in the afferent and efferent portions of the jejunum, probably gives the best assurance against obstruction. Experience in this method, while so far gratifying, should, however, be enlarged to ascertain if the increased risk of the additional button overtops the danger of the bile and pancreatic obstruction.

A Simple Method for Controlling Hemorrhage During Disarticulation at the Hip.—THOMAS (*Lancet*, April 23, 1898) details a simple method for controlling hemorrhage from the femoral artery which he used with satisfaction in an amputation at the hip.

The common femoral artery and vein were temporarily compressed immediately below Poupart's ligament. At this point the artery is quite superficial and easily felt, and is well above the origin of the deep femoral. The femoral pulse being felt, he made a stab-puncture in the skin, one about an inch outside the pulse, and the other about two inches to its inner side—*i. e.*, immediately below the pubic spine. An aneurism needle was pushed from one stab-puncture well behind the artery and vein to the other stab-puncture, and two long, thick, silk ligatures were carried back when it was withdrawn. A roll of compressible material was placed over the artery and the two ligatures tied separately over it, after the limb had been elevated for a sufficient length of time to empty it of blood. The knots are not firmly fastened at first, a surgeon's knot is used, held by hæmostats, so that they can be readily made tighter if it is found necessary.

The same result can be attained by making one puncture and pushing one blade of a Doyen's broad ligament forceps beneath the vessels, and then clamping them, but this requires an extra instrument and is not available in an emergency.

The Abdominal Incision Through the Sheath of the Rectus Muscle, with the Displacement of its Lateral or Median Margin.—LENNANDER (*Centralblatt für Chirurgie*, 1898, No. 4) has used this incision in many cases of appendicitis, and believes it is preferable except where firm adhesions hold the appendix in the lumbar region or in the lateral portion of the iliac fossa and where drainage is necessary. It is especially useful in operations during the interval, where the exact position of the appendix can usually be determined beforehand. In all cases where the cæcum and appendix are freely movable this incision gives better results and allows in women the thorough exploration of the adnexa, which are also frequently involved.

The direct incision through the rectus muscle has the disadvantages of cutting the vasa epigastrica inferiora, of generally cutting the muscular branches of the nerves and producing atrophy, and in addition the scars of the incision directly through the different layers of the abdomen are in close relation to each other.

The method the author advocates is through the skin, then through the anterior fibres of the sheath of the rectus one-half to three-quarters of an inch from the external margin of the muscle and toward the median line.

On the right side, if for appendicitis. The wound is thoroughly dried, the border of the rectus carefully freed and gently displaced inward. One or two nerves accompanied by vessels are seen now crossing the field diagonally to the muscle. The vessels are tied and cut. In almost all operations the nerves can be displaced to the upper or lower angle of the wound and remain unharmed throughout the operation. The posterior layer of the rectus sheath is now incised, and with it the peritoneum opposite the skin incision.

The wound is afterward closed by layers of sutures separate from the peritoneum and posterior layer of the sheath; the muscle is then replaced, its margin attached by sutures, the anterior layer of the sheath sutured separately. The skin is closed with deep and superficial sutures of silkworm-gut, the deep sutures including the sheath of the rectus. Drainage or even packing may be employed in the area anterior to the rectus sheath, if deemed necessary.